Prevention and Wellness Trust Fund 2013 Legislative Report

BUREAU OF COMMUNITY HEALTH AND PREVENTION

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

February 2014

Deval L. Patrick, Governor
John W. Polanowicz, Secretary, Health and Human Services
Cheryl Bartlett, Commissioner, Department of Public Health

Staff of the Massachusetts Department of Public Health prepared this report in accordance with paragraphs G and H of Section 60 of Chapter 224 of the Acts of 2012.

Chapter 224 of the Acts of 2012, Section 60, Paragraphs G and H

The department of public health shall, annually on or before January 31, report on expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be limited to: (1) the revenue credited to the fund; (2) the amount of fund expenditures attributable to the administrative costs of the department of public health; (3) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; (4) the results of the evaluation of the effectiveness of the activities funded through grants; and (5) an itemized list of expenditures used to support workplace-based wellness or health management programs. The report shall be provided to the chairpersons of the house and senate committees on ways and means and the joint committee on public health and shall be posted on the department of public health's website.

The department of public health shall, under the advice and guidance of the Prevention and Wellness Advisory Board, annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria. The report shall set forth the rationale for such strategy, including, but not limited to: (1) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation or socio-economic status; (2) a list of the most costly preventable health conditions in the commonwealth; (3) a list of evidence-based or promising community-based programs related to the conditions identified in clauses (1) and (2); and (4) a list of evidence-based workplace wellness programs or health management programs related to the conditions in clauses (1) and (2). The report shall recommend specific areas of focus for allocation of funds. If appropriate, the report shall reference goals and best practices established by the National Prevention and Public Health Promotion Council and the Centers for Disease Control and Prevention, including, but not limited to the national prevention strategy, the healthy people report and the community prevention guide.

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Executive Summary

This report summarizes the significant progress made by the Massachusetts Department of Public Health (DPH) and partner organizations toward designing and implementing programs that can achieve the goals outlined for the Prevention and Wellness Trust Fund (PWTF) in Chapter 224 of the Acts of 2012 (Chapter 224). As stated in the legislation, the PWTF will be used to achieve reductions in the prevalence of preventable health conditions and reductions in health care costs or the growth in health care cost trends. In addition, the PWTF will be used to assess which groups benefitted from any reductions and whether worksite wellness initiatives played a role in these improvements. All PWTF planning in the last year has proceeded with these specific goals in mind.

To develop a Request for Responses (RFR), which is the vehicle by which PWTF monies will be distributed, DPH worked with several partners and the Prevention and Wellness Advisory Board (PWAB) to develop a list of the most preventable and costly health conditions. Additionally, DPH held four Listening Sessions in all regions of the state in July 2013 to gather input from stakeholders and the general public. Through this process, DPH focused the resulting RFR on five key strategies:

- Use of evidence-based interventions
- Targeting of areas and populations with high disease incidence and/or high healthcare costs[1] as well as targeting risk factors and diseases that lead to significant cost savings
- Promoting strong linkages between clinical settings and community organizations and resources
- Maximizing the Return on Investment (ROI)
- Promoting sustainable changes

Additionally, all work will be accompanied by robust data collection and evaluation at the community and state levels.

An outline of the RFR was reviewed with the PWAB on August 19, 2013 and the final PWTF RFR was posted on August 29, 2013. Thirty-two letters of intent were received by the September 27, 2013 deadline and 20 applications were received by the November 1, 2013 deadline.

After a comprehensive review process, nine partnerships will receive funding with an anticipated start date by March 1, 2013. The nine partnerships will be organized in two distinct cohorts. Cohort 1 includes partnerships led by Holyoke Health Center, City of Worcester, Boston Public Health Commission (North Dorchester and Roxbury), City of Lynn, and Manet Community Health Center (Quincy and Weymouth). Cohort 2 includes partnerships led by Barnstable County Department of Human Services (Barnstable, Mashpee, Falmouth, Bourne), New Bedford Health Department (New Bedford and Fall River), Town of Hudson (Framingham, Hudson, Marlborough, Northborough), and Berkshire Medical Center (Berkshire County).

[1] This strategy intentionally highlights the importance of encouraging a focus on populations experiencing health disparities based on race, age, income, or geography.

Each awardee in Cohort 1 will each receive approximately $250,000 for up to six months to conduct capacity-building activities. Implementation funding will be provided when specified benchmarks have been met by these grantees. Each awardee in Cohort 2 will receive capacity-building funds of approximately $250,000 for up to 10 months. During the initial months of funding, these programs will be refining their proposals including their service area, health conditions/interventions, and/or population(s) of focus. They will be provided enhanced support and technical assistance from DPH to further shape this work and, as they finalize their revised plans move forward into capacity-building activities, to meet specified benchmarks.

DPH looks forward to providing continuous support for these grantees as they work in collaborative partnerships among clinical settings, community organizations, municipalities, and regional planning agencies to reduce the prevalence of and health care costs associated with these health conditions in their communities. Additionally, DPH, working with the PWAB, is developing a comprehensive evaluation plan to monitor progress towards meeting the goals set out in Chapter 224.

Over the four-year life of the program, the PWTF will receive $57 million. The PWTF budget for the four years allocates $8,550,000 (or 15%) for administrative and evaluation expenses including staff and contractors to support evaluation, technical assistance, IT, and other support for funded partnerships. $42,750,000 has been budgeted to fund grants and $5,700,000 for worksite wellness activities.

Through November 30, 2013, the Trust received $18,914,812.41 with current expenses totaling $177,862.07. The funds expended to date include $126,386.14 for staffing related costs and $51,475.93 for consultant and logistical support for the listening sessions, bidders' conference and RFR. These expenditures constitute 0.94% of funds received to date and 0.31% of total funds anticipated over the four-year life of the program.

Setting the Course for the Prevention and Wellness Trust

Section 276 of Chapter 224 provides clear goals for the Prevention and Wellness Trust Fund (PWTF). Within this statutory framework, the roadmap to achieve those goals could follow many different paths. This report focuses on the decisions made by the Department of Public Health (DPH), in consultation with the Prevention and Wellness Advisory Board (PWAB), that have shaped the course of work supported by the Prevention and Wellness Trust. The vision for PWTF presented here was developed by working backward from the goals specified in Chapter 224.

The five explicit goals in Section 276 of Chapter 224 are:

1. A reduction in the prevalence of preventable health conditions;

2. A reduction in health care costs or the growth in health care cost trends;

3. An assessment of which groups benefitted from any reduction;

4. An assessment of whether workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; and

5. If employee health and productivity was improved or employee recidivism was reduced, an estimate of the statewide financial benefit to employers.

Clearly, the PWTF goals are ambitious. Given the upward trend in health care costs, any program that achieves a measurable decrease in the prevalence of preventable health conditions and the health care costs associated with these conditions in less than four years will be a model for other states embarking on this path.

DPH has embraced these goals and sought to develop a plan for PWTF that maximizes the chances of achieving them.

Beginning in October 2012, staff at DPH developed a list of key unanswered questions that were critical to the development of the Request for Responses (RFR) for the Prevention and Wellness Trust. These preliminary questions were:

1. Which costly health conditions had the greatest potential for short-term return on investment?

2. Would the PWTF programs be more successful if they were implemented in single or multiple domains (e.g., community, clinical, and community-clinical linkages)?

3. What was the optimum population size and optimal funding amount for this work?

4. What was the best method to ensure that every applicant pays proper attention to health disparities and health equity issues?

5. What was the feasibility of requiring each PWTF awardee to include a bi-directional electronic referral system linking clinical and community sites? (Note: DPH was awarded funds to develop an e-referral program as part of the State Innovation Model Testing Award funded by the Centers for Medicare and Medicaid Services (CMS).)

This report describes how DPH addressed these questions in its design of the PWTF program.

Background

Chapter 224 is comprehensive health reform legislation that focuses on improving the quality of care and reducing health care costs. Implementation of the PWTF is therefore situated in this overall framework for health care cost containment. In addition, the PWTF builds on national efforts and expands current DPH federally funded grants and programs in four distinctly different ways. This synergy ensures that communities and healthcare systems will work together to build a sustainable, collaborative, data-driven partnership that permanently links their efforts to improve health while simultaneously helping to control the growth of healthcare costs.

First, interventions will be evidence-based and results will be measured by data. Primary data sources will include medical claims from the All-Payer Claims Database, MDPHnet (the state's ambulatory surveillance system), an e-Referral system developed through a Centers for Medicare and Medicaid Services (CMS) State Innovation Model Testing Award, and participating clinicians' electronic health records (EHR). With the availability of data, all quality improvement (QI) efforts will be based on measureable targets and grantees will regularly and formally share best practices with each other. They will also be coached by experts to achieve these goals. As a model, PWTF will parallel the efforts of the Massachusetts Paul Coverdell National Stroke Registry, funded by the Centers for Disease Control and Prevention (CDC). Coverdell uses this data-driven, quality improvement approach and has had significant success measuring short-term progress toward achieving national benchmarks for stroke care.

Second, as most people with chronic diseases spend the majority of their time living, working, and going to school in the community, more chronic disease prevention and control needs to happen in the community setting. This work also needs to be linked to clinical practices, which can serve as access points for primary, secondary and tertiary prevention services. Therefore the National Prevention Strategy, the National Quality Strategy, and the Expanded Care Model are promoting the linking of clinical practice with community resources to help prevent and control chronic diseases. In recent years, public health has increased its efforts to link more effectively with health systems by using community resources and supportive environments to complement and strengthen delivery of clinical care. The PWTF will build on these national efforts and become the driving force to expand the current CMS State Innovation Model Testing Award e-Referral project where significant numbers of patients are electronically referred by clinicians to community organizations/resources and their progress can be evaluated.

Third, treatment and prevention strategies for many chronic conditions should be more effectively integrated. People frequently have more than one chronic condition. Consequently, healthcare providers and public health programs need to be able to treat the entire complex person and not a single disease. Recognizing this, the recent national CDC Funding Opportunity Announcement (FOA) CDC-RFA-DP13-1305 *State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health* consolidated and integrated what had been formerly individual funding opportunities for state Departments of Health and Public Health. In this FOA, CDC states "that the diseases, conditions and risk factors public health programs address are interrelated and often co-occur; and the strategies used to address risk factors and improve health are complementary and often similar across programs." The Trust follows this integrated approach by utilizing interventions and programmatic expertise from many DPH programs. Among them are: Mass in Motion, Community Transformation Grants, Coordinated Chronic Disease Communities of Practice, Consolidated Chronic Disease Funding (CDC-RFA-DP13-1305), Tobacco, Falls Prevention, Asthma, Substance Abuse, as well as the recently implemented Wellness Tax Credit (Sections 41 and 56 of Chapter 224).

Fourth, multi-sector interventions have proven to be cost-effective. By ensuring that changes in clinical care and community support systems occur simultaneously, we can improve the population's health and control costs. Simultaneous change has proven to be more effective than

addressing these systems separately. In *Multisector Partnerships in Population Health Improvement*, the authors concluded "that systems thinking — accounting for the collective effect of many actors and actions — is essential to organizing and sustaining efforts to improve population health, and to evaluating them."[2] Therefore, the grantees of the PWTF will be required to form partnerships that work together to simultaneously improve clinical care, develop individual behavior change programs and link patients between systems to control and prevent selected priority conditions as well as change policies and systems in both settings to build sustainable change. Please refer to Appendix A for descriptions of the initiatives the Trust is building upon.

As DPH reviewed evidence and explored varying approaches to implement the PWTF, the Department sought input from health advocacy groups and other experts in the field.

The Prevention and Wellness Advisory Board

The Prevention and Wellness Advisory Board, established in Section 60 of Chapter 224, is charged with informing the plans for the expenditure of PWTF funds. The Prevention and Wellness Advisory Board (PWAB) consists of 17 members. The members of the Prevention and Wellness Advisory Board are:

Governor-Appointed Positions	
Qualification	Board Member
Public Health Economics	David Hemenway, PhD
Public Health Research	Stephenie C. Lemon, PhD
Health Equity	TBA
Local Board of Health (population over 50,000)	Paula Johnson, MD, MPH
Local Board of Health (population less than 50,000)	Heidi Porter MPH, REHS, RS
Health Insurance Carrier – position 1	MaryLynn Ostrowski, PhD
Health Insurance Carrier – position 2	Cathy Hartman, MS
Consumer Health Organization	Susan Servais, BA,CAE
Hospital Association	Peter Holden, MD
Statewide Public Health Organization	Tobias Fisher, MBA, MSW[3]
Interest of Businesses	Keith Denham
Public Health or School Nurse	Karen Regan, RN, BSN
Administrator of an Employee Assistance Program	Robert Bruce Cedar, EdD
Association of Community Health Workers	Lisa Renee Holderby-Fox
Ex-officio Positions	

[2] Woulfe J, Oliver TR, Zahner SJ, Siemering KQ. Multisector partnerships in population health improvement. Prev Chronic Dis 2010;7(6):A119. http://www.cdc.gov/pcd/issues/2010/nov/10_0104.htm. Accessed on 12/31/2013.

[3] The position on the Advisory Board representing a statewide Public Health organization is currently vacant. Mr. Tobias Fisher was appointed but has left the position.

Commissioner, Department of Public Health	Cheryl Bartlett, RN, Chair
Secretary, Executive Office of Health and Human Services	John Polanowicz
Executive Director, Center for Health Information and Analysis	Lori Cavanaugh (designee)

For brief biographies of the appointed members of the PWAB, please see Appendix B.

Section 60 of Chapter 224 delineates the responsibilities of the PWAB. The Board is responsible for making recommendations to the Commissioner of DPH on the following:

- Administration and allocation of Prevention and Wellness Trust Fund
- Developing guidelines and for an annual progress review by grantees
- Reporting annually to the legislature on its strategy for administration and allocation of the fund

To accomplish these obligations, the PWAB has met four times in 2013 (on June 27, July 29, August 19 and December 16). Agendas, materials and minutes are posted at http://www.mass.gov/eohhs/gov/newsroom/open-meeting-notices/dph/prevention-and-wellness-advisory-board.html.

The first three meetings of the PWAB set goals specific to guiding the expenditure of the Prevention and Wellness Trust Funds through the development of a Request for Responses (RFR). The fourth meeting helped guide the preparation of this first annual report to the Legislature as well as plans for the evaluation of grantee progress in the coming year and beyond. Full meeting agendas can be found in Appendix C.

Summarizing the Evidence Base

The outcome measures defined in the legislation as well as the national movement toward integrated public efforts and the importance of obtaining input from the PWAB all shaped the core elements of the PWTF RFR that was released on August 29, 2013. Much work went into development of the RFR and many important decisions were made. As part of this first report, the Board felt it would be useful to explore the justification for choices made that will guide the activities of the Prevention and Wellness Trust in the years ahead.

Chapter 224 states that the interventions proposed need to be evidence-based (Chapter 224, Section 60, Paragraphs d, e, and h). In an effort to determine those evidence-based interventions that would have the highest likelihood of meeting the ambitious goals of Chapter 224, DPH examined 13 health conditions with substantial evidence for simultaneously improving health and reducing health care costs. These were asthma, cancer, congestive heart failure, hyperlipidemia (i.e., high cholesterol), injuries from unintentional falls, hypertension, mental health/depression, obesity, oral health, stroke, substance abuse, tobacco use, and type 2 diabetes. DPH engaged the Prevention and Wellness Advisory Board to determine which conditions, and associated evidence-based interventions, would be prioritized through the RFR.

To facilitate this discussion, DPH prepared two-page fact sheets for each of the 13 health conditions listed above. The work required DPH staff to examine health conditions with evidence bases that varied in depth and quality. Most of these health conditions had never been

evaluated using a common framework like that found in the graded recommendations prepared by the United States Preventive Services Task Force (http://www.uspreventiveservicestaskforce.org/). Given the scope of this effort, DPH sought guidance and advice from groups such as the Health Policy Commission, the Center for Health Information and Analysis, specific offices at the Centers for Disease Control and Prevention, as well as faculty from the Harvard School of Public Health and the University of Massachusetts Medical School.

The fact sheets prepared by DPH can be found in Appendix D. They were designed to give succinct but comprehensive information about each potential health condition of focus; the information given is specifically focused on the outcome measures outlined in Chapter 224. Each fact sheet includes a brief summary of the condition and associated risk factors; data such as prevalence and incidence, rates of hospitalizations, emergency department visits, and impact upon primary care; information about cost and cost trends; geographic distribution of the condition across the state; disparities, including those related to race, age, and income, in prevalence and incidence of the condition; clinical quality measures that may be directly tied to cost savings; and a list of evidence-based interventions that have been shown to be effective in addressing each condition. In addition, each fact sheet contains information about potential cost savings for the condition in a three-year, five-year, and ten-year period if the condition were effectively addressed using evidence-based interventions. Finally, the health conditions covered in these fact sheets represent the list of the most prevalent preventable health conditions in Massachusetts. Disproportionate prevalence by disparity populations was recognized in each fact sheet with specific references to race, ethnicity, gender, disability status, sexual orientation and socio-economic status. Consistent with Chapter 224, section 60, paragraph H, each fact sheet included assessments of the evidence base for community-based and worksite wellness programs related to each of these conditions.

The evidence-based interventions listed on the second page of each fact sheet were graded as "A," "B," or "C" by content experts within DPH using a system similar to that employed by the U.S. Preventive Services Task Force. This grading system allows readers to ascertain quickly whether there is clear evidence for the success of the intervention using well-conducted randomized control trials (grade A), whether there is supportive evidence from other well-conducted studies (grade B), or whether the evidence for success consists of expert consensus or clinical experience (grade C). After reviewing the evidence in this way, it became clear that the interventions funded by PWTF should focus primarily on secondary and tertiary prevention. Primary prevention interventions, though worthy, would not yield the health and health cost outcomes set forth in Chapter 224 within the four-year timeframe provided.

Working with the Prevention and Wellness Advisory Board

Prior to the first meeting of the Prevention and Wellness Advisory Board, board members received the two-page fact sheets described above. The fact sheets were a significant focus of the first PWAB meeting on July 27, 2013. Members were asked to review the materials and to rank each condition with respect to how appropriate it would be as a condition of focus for the PWTF RFR. As part of this ranking process, the Board was asked to consider key questions including whether the condition was amenable to meeting the outcomes defined in the legislation if

addressed, the strength of the evidence base for interventions addressing the condition, the extent to which they would expect applicants to address the condition effectively, and the degree to which the interventions could be properly and conclusively evaluated.

Highlights of PWAB Meeting #1, June 27, 2013

- Approval of remote attendance to meetings as an alternative in an emergency situation.
- Discussion of conflict of interest for members who may be interested in applying for funds.
- Presentation by David Seltz, Executive Director of the Health Policy Commission on the background of Chapter 224 and the role of the Health Policy Commission.
- Presentation and discussion of proposed timeline for writing and release of the RFR.
- Discussion of PWTF *Guiding Principles* and *Vision* and obtaining consensus on language.
- Homework Assignment: Members were presented the two-page fact sheets on 13 prevalent health conditions in Massachusetts. Prior to the second meeting on July 29, 2013, members were asked to rank which conditions should be the focus of the RFR and to include a brief narrative as to the rationale for their selections. Questions were offered to guide their decisions:
    - What is it about this condition that suggests it should be a priority? Consider prevalence, cost estimates, measurable ROI, geography, disparities, etc.
    - How/why does this condition distinguish itself from others?
    - How strong is the evidence base of interventions for this condition?
    - To what extent do you expect applicants will be able to effectively address this condition?
    - To what degree do you expect interventions for this condition can be properly and conclusively evaluated?

The Board's average rankings were presented during the second meeting on July 29, 2013. After a discussion of conditions with the greatest potential for short-term return on investment, several conditions rose to the top for consideration as conditions of focus: pediatric asthma, tobacco use, prevention of unintentional falls, hypertension, oral health, mental health/depression, obesity, substance abuse, and diabetes. The Board's consideration and discussion were used as the basis for an RFR that would fund partnerships to implement evidence-based interventions aimed at secondary prevention for these conditions in communities across the Commonwealth. The Board also advised the Commissioner of the Department of Public Health to include "evidence-informed" interventions so that the Trust could promote innovation and help build the public health evidence base.

Highlights of PWAB Meeting #2, July 29, 2013

- Presentation on Conflict of Interest by Lisa Snellings, DPH Counsel, and David Giannotti, Chief, Public Education and Communications Division, State Ethics Commission.
- Commissioner Bartlett reviewed the timeline for posting the RFR, receiving applications and awarding grants.
- Review of ranking for 13 chronic diseases or conditions. An open discussion followed on each of the 13 conditions with board members presenting both pros and cons.
- Summary of the input received at listening sessions that were held in New Bedford, Boston, Holyoke and Worcester. Board members discussed the listening sessions and offered numerous suggestions for the RFR.
- Review of outcome measures as defined in Chapter 224.
- Iyah Romm, Director for System Performance and Strategic Investment, Health Policy Commission, provided an overview of the Health Policy Commission CHART Grants.
- PWAB Members were asked if they would like to participate in RFR application reviews.

In July 2013, DPH also held four Listening Sessions in all regions of the state to gather advice and input about the upcoming RFR from stakeholders, potential applicants, and the general public. Approximately 300 people attended these listening sessions in Boston, Holyoke, Worcester, and New Bedford (a summary of the listening session can be found in Appendix E). One common them from these sessions was a desire to ensure that the RFR would adequately address health disparities and health equity issues. This feedback was incorporated into the RFR, which required applicants to describe populations with disproportionate disease burden, services utilized by disparity populations, and outreach plans for those groups still not receiving adequate care.

The development of the 2-page fact sheets also led DPH evaluators to examine questions about the optimum number of awards and the optimal per capita amount of funding for each awardee. To lay the foundation for discussions with the PWAB about these issues, DPH evaluation staff examined large multi-sector, multi-factor interventions programs like the Community Transformation Grants and the Childhood Obesity Demonstration Grant as well as return on investment studies of worksite wellness programs.[4] It was clear from these studies that investing too little in a community was just as problematic as investing too much to successfully achieve return on investment. While there is no universally accepted methodology for determining the optimal population size and optimal per capita funding level, the figure below summarizes the information gathered at DPH to guide the decisions about number and size of awards.

Figure 1 below applies three different lenses to determine the appropriate population size for the PWTF funds:

[4] DPH has previously summarized information about worksite wellness programs in its Model Wellness Guide (http://www.mass.gov/eohhs/docs/eohhs/wellness-tax-credit/model-wellness-guide.pdf.)

1. The total reduction in healthcare costs necessary to recoup the $60 million across different population sizes,
2. The intensity/costliness of interventions, and
3. The effectiveness of interventions.

The heavy black line indicates the percent reduction in total healthcare costs that must be achieved in order to recoup the $60 million investment from the PWTF. If the total service area served by programs supported by these funds included only 50,000 people, total healthcare costs would have to be reduced by nearly 3% across the population in order to achieve the required cost savings. If funds supported programs serving a population of roughly 1,000,000 people, however, the health care cost reduction on a percentage basis necessary to achieve a $60 million savings would be approximately 0.2%.

Next, staff looked at what effective programs spent per capita using worksite wellness programs as an example; these programs spent a range of $50 to $500 per person. As the programs themselves vary in their effectiveness, studies were examined to see what kind of returns on investment (ROI) we might expect for well-implemented interventions. While some individual programs have very high ROI, they impact a fairly small number of people. When these results are distributed across the full population, the ROI is much lower. Based on the studies examined, the best case return would be about 1% across the full population. However, the ROI would be expected to decrease as the population size increases because there would be less money invested on a per capita basis.

The light gray area indicates the maximum possible ROI for effective interventions. The peak for ROI occurs when the total population covered by all grantees reaches approximately 600,000 people.

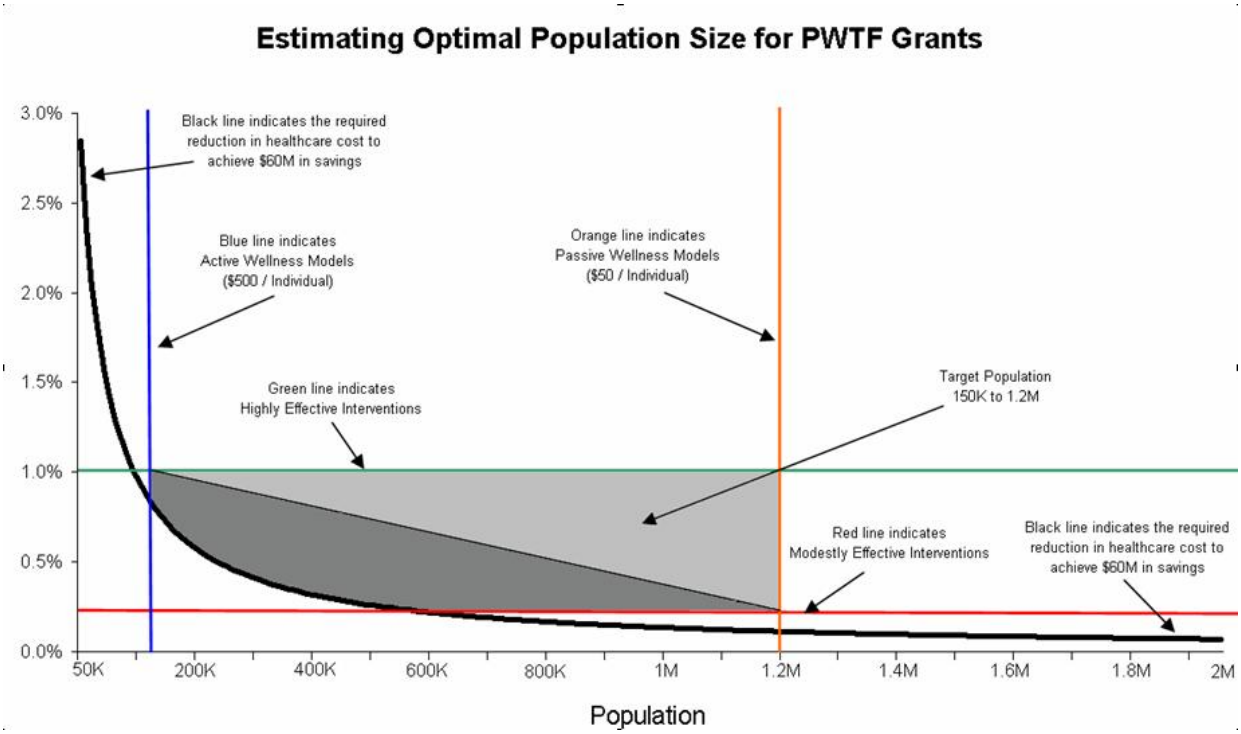


Figure 1. Estimating Optimal Population Size

Based on this analysis, DPH proposed a cap of no fewer than six awards and no more than 12. Each award would focus on a population between 30,000 and 120,000 people. Annual award amounts would range from ~$250,000 in the capacity building phase that would last no more than six months and $1.1 million to $2.5 million per year for the remaining three years when programs were fully implementing the interventions. In order to be funded for this implementation work, groups would be required to meet certain specific benchmarks in the capacity-building phase. In addition, DPH proposed that awards would be made to partnerships comprised of at least one municipality, one community organization, and one clinical partner. Only one application would be reviewed per service area. All potential applicants would be required to submit a Letter of Intent prior to the application due date. These recommendations were offered for discussion at the second meeting of the PWAB on July 29, 2013.

During this meeting, some members of the PWAB expressed concern about the number of proposed awards in addition to the proposed population size covered by each award. This concern was also expressed by some key stakeholders and public health advocates. At the end of these discussions, however, it was agreed that focusing resources in 6-12 awards had the greatest potential for achieving the outcomes, including ROI, defined in the legislation.

A framework for scoring applications was presented to the PWAB during at the August 19, 2013 meeting and the Board affirmed the basic approach. In that framework, approximately 65% of the total technical score would be to given questions assessing the partnership and proposed population of focus (including burden of health conditions and history of and plans to address these conditions among vulnerable populations); approximately 25% of the scoring was allotted

for health interventions and the proposed infrastructure of the partnership; and approximately 10% of the technical score was allotted for considerations of sustainability and budget. For the second level review, additional considerations were discussed such as the overall strength of the proposal, plans to address health disparities, geographic distribution of awards, past performance of partnering agencies, and the proposed budget. Approximately 50% of the overall score of each application would be composed of the technical score and 50% composed of the score at the second level. The proposed elements of the entire RFR were also presented for comment to the PWAB at the August 19, 2013 meeting. Based on that discussion with the PWAB, some changes were made to the developing RFR (noted in italics below).

Highlights of PWAB Meeting #3, August 19, 2013

- Commissioner Bartlett reviewed key aspects of the draft RFR:
  - Six to twelve awards with suggested funding levels of:
    - Year 1: roughly $250,000 per awardee – capacity building
    - Year 2: roughly $1.1-2.2 Million per awardee – implementation
    - Year 3: roughly $1.2-2.5 Million per awardee – implementation
    - Year 4: roughly $1.1-2.2 Million – moving toward sustainability
  - Health conditions to be addressed:
    - Priority: tobacco use, asthma (pediatric), hypertension, fall prevention (older adults); Expect all grantees to address all four *(this was amended to require that two of the four priority conditions be addressed)*
    - Optional conditions: Obesity, diabetes, oral health, substance abuse *(mental health was added)*
    - Other conditions: applicants can propose others
    - Focus on vulnerable/disparate populations
  - Letters of Intent were REQUIRED**.**
  - Service areas should include populations between 30,000 and 120,000.
  - Partnership requirements: Each must have a municipality, a community-based organization, and a clinical health provider. No overlapping geographies.
  - Partnerships must accomplish benchmarks to move to implementation phase.
  - Partnership need to develop a plan for sustaining interventions beyond 2017.
- Framework for scoring applications reviewed.
- Board members shared their concerns and offered advice about RFR framework.
- Presentation and discussion on e-referrals, the CMS State Innovation Testing Award and how it connects to the PWTF.
- Presentation and discussion on the Evaluation Approach for the PWTF.

The resulting RFR required applicants to address at least two of four priority conditions: pediatric asthma, hypertension, tobacco use, and falls among older adults. Applicants were also encouraged to address mental health/depression and substance abuse as co-morbid conditions and were permitted to address other optional conditions (obesity, diabetes, oral health, substance abuse/mental health).

In addition, the RFR focused on five key strategies:

- Use of evidence-based interventions
- Targeting of areas and populations with high disease incidence and/or high healthcare costs[5] as well as targeting risk factors and diseases that lead to significant costs savings
- Promoting strong linkages between clinical settings and community organizations and resources
- Maximizing the Return on Investment
- Promoting sustainable changes

The final RFR was posted on August 29, 2013 (See Appendix F for the text of PWTF RFR). A Bidders' Conference was held in Sturbridge, Massachusetts on September 12, 2013. The basic framework of the RFR and the scoring system were presented at that meeting. This public forum offered potential applicants an opportunity to ask DPH questions about the elements of the RFR. Based on these meetings, the date for the required Letter of Intent was extended by eight days to September 27, 2013 and the deadline for completed applications was extended by 17 days to November 1, 2013. Between August 29, 2013 and October 16, 2013, individuals could submit written questions to DPH. Responses to 127 questions were posted to Comm-PASS for all potential applicants to review.

Progress on e-Referrals

The Massachusetts Executive Office of Health and Human Services applied for a CMS State Innovation Model Testing Award in the fall of 2012 and was one of six states funded in the spring of 2013. As part of that application, DPH proposed creating an open-source, bi-directional software tool that would enable clinical providers to refer their patients to community resources (e-Referral system). The e-Referral program was funded at $3.8 million for four years. This CMS State Innovation Model Testing Award funding will allow the DPH to develop and test the open-source software, implement the software in up to nine community health centers and affiliated community organizations over three years, and conduct an extensive evaluation on both the e-Referral system and health outcomes associated with receiving community services through this system.

The e-Referral project anticipates finishing software development and piloting the e-Referral open-source software in three pilot sites in 2014. These pilot sites will be three community health centers with a connection to several community-based organizations (at a minimum the YMCA, Councils on Aging/Healthy Living Center for Excellence for chronic disease self-management, a visiting nurse association, and the state tobacco quitline). In addition to starting to make referrals on this new system, the e-Referral project team will capture user-feedback and electronic medical record data from these initial pilot sites to conduct an early evaluation on e-Referral system use, impact on community based program referrals, and short-term health outcomes.

An RFR was posted in September 2013 to fund three coalitions led by community health centers (CHCs). The community partners in these coalitions will be linked electronically to a CHC in order to deliver services to the CHC patients. Starting in April of 2014, the DPH will begin

[5] This strategy intentionally highlights the importance of encouraging a focus on populations experiencing health disparities based on race, age, income, or geography.

contracts with three selected community health centers. These pilot sites will convene with their community-based organizations to finalize specific referral types, data required to initiate a referral from the CHC, number of feedback reports required for each referral type from a community-based organization, and data elements contained in the feedback reports. Each CHC will also work with the Massachusetts League of Community Health Centers (MLCHC) for electronic health record (EHR) technical support and clinical workflow. Specifically each CHC will engage with the MLCHC to modify their EHR to push referral data out and receive referral data back into the system. In addition, the MLCHC will provide clinical workflow expertise to support the incorporation of e-Referrals into primary care visits. The e-Referral IT staff will be responsible for training the community-based organizations in using the e-Referral Gateway. In June 2014, when the e-Referral software is ready to launch, the CHCs will be in place to successfully send electronic referrals and receive feedback information. From that point forward, the e-Referral project team will be in contact with all pilot sites, monitor e-Referral activity, provide technical assistance for any problems that arise, and begin a preliminary evaluation of short-term health outcomes associated with referral types (e.g., pounds lost, lowered blood pressure). A graphic depiction of the e-Referral system as it will be deployed for PWTF can be seen in the Figure 2 below.

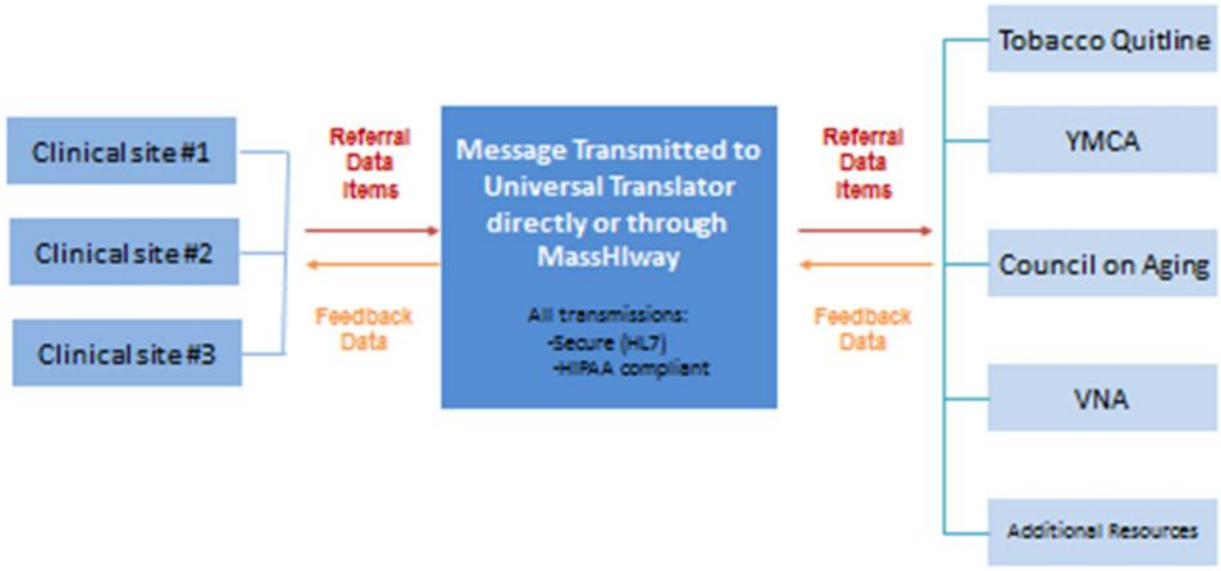


Figure 2. Schematic of PWTF e-Referral System

The benefit of this grant to the PWTF will be to pilot and subsequently make available this free software for any of the funded partnerships. This bi-directional software, which will be compatible with most EHR platforms, will enable clinical partners to make referrals to community-based organizations for evidence-based interventions as well as linkage to community health workers and for these community providers to enter information regarding the uptake and completion of interventions. Applicants to the PWTF RFR were required to have at least one clinical partner commit to using its EHR to make bi-directional electronic referrals.

Letters of Intent

By the deadline of September 27, 2013, DPH received a total of 32 Letters of Intent (LOI) for the Prevention and Wellness Trust Fund grants. Twenty-eight of the LOIs were complete, meaning all requested information was included in the submission of these 28. The remaining four LOIs included insufficient information related to the intended service area or the applicant did not select at least two priority health conditions. In addition, four LOIs had overlapping service areas. As stated in the RFR, in an effort to eliminate this overlap DPH posted a list of all LOIs received on Comm-PASS and required applicants to resolve these conflicts.

The service areas defined in the LOIs had a higher than average health burden when compared to the state as a whole. Tobacco Use and Pediatric Asthma in these areas were significantly higher than the state average, while Hypertension and Falls Among Older Adults were marginally higher. Twelve LOIs planned to address all four priority health conditions. The minimum number of health conditions selected was two. The maximum was eight, which included optional and other conditions. The average was 3.9. Of the 16 LOIs that selected fewer than four priority health conditions, only seven selected those health conditions with the highest average health burden in their proposed service areas.

At least six LOI defined service areas with populations greater than 120,000. No LOI had a population of less than 30,000. Potential applicants were told that any applications received with a service area population greater than the threshold defined in the RFR may not score as high as those within the population boundaries. The geographic distribution of service (catchment) areas as defined by the LOI shows that every region of the state was represented. There were LOIs with service areas from urban, suburban, and rural areas. Service areas included 12 of the 14 counties in Massachusetts.

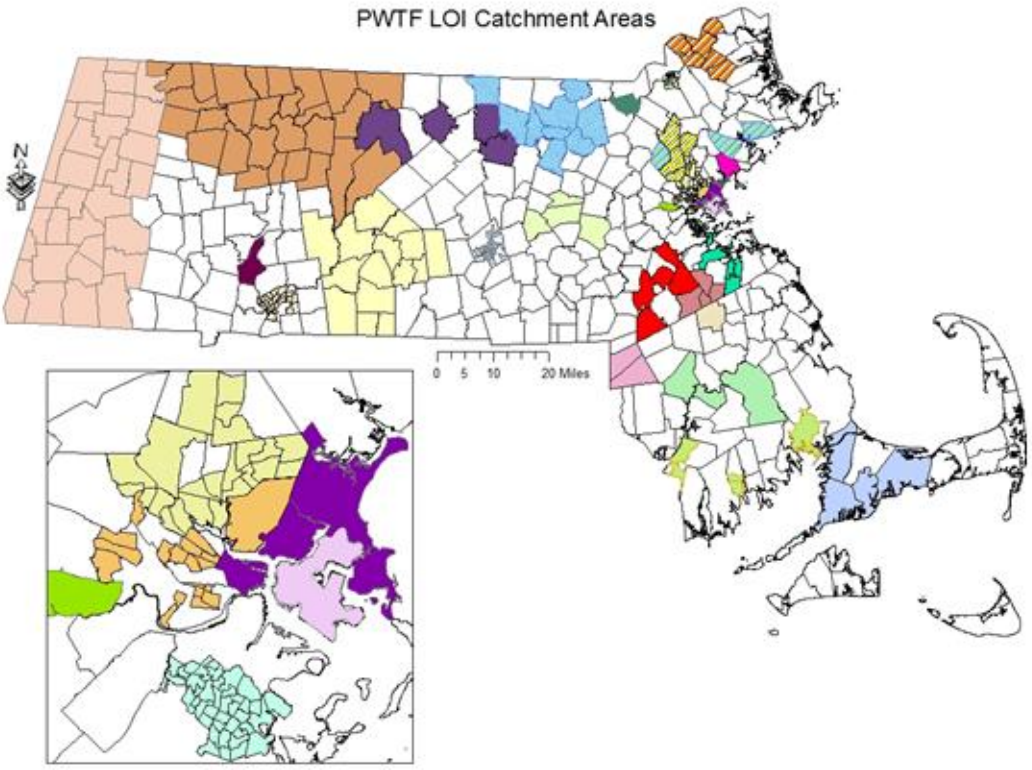


Figure 3. Catchment Areas of LOI Received by DPH

Applications Received

By the deadline on November 1, 2013, the Department received 20 applications from partnerships across the Commonwealth. Applications were received from every region of the state and covered all four priority health conditions; they included an average of 15 partners addressing an average of three priority health conditions per application. Hypertension was addressed in 16 applications, tobacco use in 15, falls among older adults in 15 applications, and pediatric asthma in 13. Optional conditions addressed in the applications include obesity (five), diabetes (four), substance abuse (four), and all others (four). Approximately 60% of health conditions targeted by applicants included an e-referral strategy; all applications had at least one intervention that involved e-referrals. The average population in the proposed service areas was approximately 108,000.

Consistent with DPH standard practice, applications were scored at two levels. A technical level review assessed the quality and completeness of responses, while a second-level review assessed the overall strength of the proposal, plans to address health disparities, geographic distribution of awards, past performance of partnering agencies, and a detailed consideration of the proposed budget.

The technical reviews took place from November 12 through November 26, 2013. Nine review teams, involving more than 50 staff, scored two to three applications each. Each review team met

for a daylong session to score applications, though one review team met over two days. Reviewers were instructed that they should score based solely on the information provided in the application and that applications should be assessed using an approach where an "adequate" score is considered as a baseline, with justifications provided if a response fell above or below the range. The average score of all applications was 240 points out of a possible 350 with a range of 192-266.

In preparing for the second-level review process, the specific interventions proposed as part of each application were reviewed by subject matter experts within DPH for further assessment of the appropriateness of the interventions for the populations of focus listed in each application, the evidence base underscoring any innovative interventions proposed, and the level of understanding of each partnership of the requirements for implementing each intervention in each domain. The comments from these subject matter experts were summarized along with the scores from technical reviewers and provided as supplemental information for reviewers during the second-level review process.

The second-level review took place on December 4, 5, and 6, 2013. Reviewers included senior-level team members from several bureaus and offices within DPH, as well as external reviewers from the Prevention and Wellness Advisory Board, the Health Policy Commission, and the Center for Health Information and Analysis. Each reviewer read two applications with the exception of two internal DPH reviewers who read 10 applications each, thereby assuring that each application had been thoroughly read by at least two members of the second-level review team.

During the second-level review sessions, the readers of each application made a detailed presentation of their assessment of the application according to the criteria listed in the second-level scoring review tool. The three-day process was facilitated and recorded by staff involved in designing the RFR and application. Each proposal was eligible for 350 points at second-level review and reviewers scored the applications using the following criteria:

- Strength of the lead agency and strength of linkages with partners.
- Quality of the proposed interventions (e.g. evidence base) and their alignment with the needs/health risks of the population.
- Readiness to implement proposed interventions within six months.
- Ability to implement a bi-directional e-referral system.
- Geographic distribution of awards with the intent of achieving an equitable distribution of awards across the Commonwealth.
- Additional weight was given to applications that included more than two priority health conditions.
- Ability to deliver return on investment

At the second-level review, two proposals were judged to be ineligible due to the fact that all health conditions did not have at least one proposed activity in each of three domains: community, clinical, and community-clinical linkage. The RFR specified that an application would be considered non-responsive if it did not meet this requirement. These proposals were scored, however, in order to provide feedback to applicants should they request it.

As a result of the review process, DPH recommended funding nine proposals in two distinct cohorts. Below are the lead agencies/communities of the successful proposals:

Cohort 1:

- Holyoke Health Center, Inc.
- City of Worcester
- Boston Public Health Commission (North Dorchester and Roxbury)
- City of Lynn
- Manet Community Health Center, Inc. (Quincy and Weymouth)

Cohort 2:

- Barnstable County Department of Human Services (Barnstable, Mashpee, Falmouth, Bourne)
- New Bedford Health Department (New Bedford and Fall River)
- Town of Hudson (Framingham, Hudson, Marlborough, Northborough)
- Berkshire Medical Center (Berkshire County)

Each awardee in Cohort 1 will receive approximately $250,000 for up to six months to conduct capacity-building activity. Implementation funding will be provided when specified benchmarks have been met by these grantees.

Each awardee in Cohort 2 will receive capacity-building funds, approximately $250,000, for up to 10 months. During the initial months of funding, these programs will be refining their proposals including their service area, health conditions/interventions, and/or population(s) of focus. They will be provided with enhanced support and technical assistance from DPH to support this work and, as they move forward into capacity-building, to meet specified benchmarks. Should these benchmarks be met, implementation funding will be awarded at a to-be determined funding level based upon the plans developed during their capacity building phase.

The anticipated start date for the awards is March 1, 2014.

The Prevention and Wellness Advisory Board met for a fourth time on December 16, 2013. The primary agenda items were a review of a draft of this report and a discussion of plans for the evaluation of grantee progress in the coming year and beyond.

PWTF Evaluation Plan

In October 2013, DPH released a Request for Quotation (RFQ) to build a team of public health evaluators from academic institutions across Massachusetts. The evaluation will be conducted in three phases: planning, data collection, and data analysis. Based on the responses, DPH has contracted with a team of evaluators for the planning phase. The evaluators represent Harvard School of Public Health, the University of Massachusetts Medical School, Northeastern University, and John Snow Inc. The first meetings with groups took place on December 11, 2013, where certain evaluation principles were proposed and adopted by the overall team. These

principles include utilization of the All Payer Claims Database, the necessity of continuous data collection, a requirement for linkages between clinical and claims data as well as a requirement for linkages between clinical data and community experiences and/or delivery of services, and to the extent possible the creation of a person-centric or context driven analysis. In other words, the analysis should look at the unique characteristics of each individual. We shouldn't just focus on the clinical measures collected at a doctor's office but also on the community in which an individual lives or works and the policies and environments that may affect a person's health. Without this context, it would be difficult to know whether any positive changes in population health were due to the interventions funded by PWTF or a host of alternative explanations. At the first meeting of the PWTF Evaluation Planning Team, subgroups were also formed to look at data sources, data linkage methodologies, data storage, data privacy, outcome measures for QI work in priority health conditions, and appropriate analytic methods for assessing something as vast as PWTF.

At the heart of the PWTF evaluation is a sophisticated system of data linkage. Below are our descriptions of current DPH data resources and how they might link together for an optimal evaluation of Prevention and Wellness Trust Fund activities:

Clinical and Cost Data Available Resources

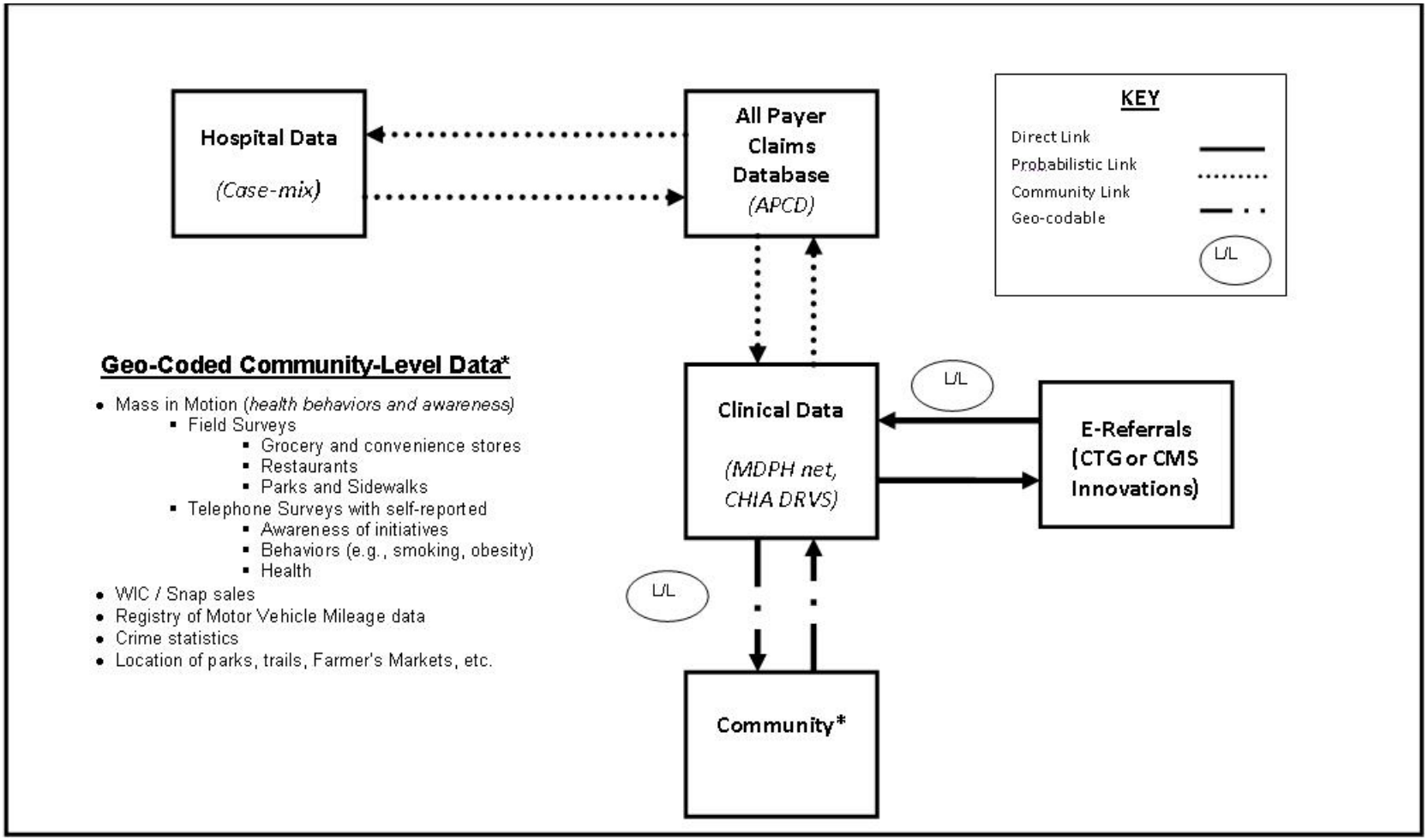
- **Clinical:** DPH has access to ambulatory clinical data both through the MDPHnet and through its relationship with Community Health Centers. Hospitalization data is available through the Case Mix Dataset from CHIA. These data sources will allows DPH to track improvements in health outcomes (e.g., control of hypertension, reduced hospitalizations, reduced cardiovascular incidents) within communities.
- **Cost:** DPH has received access to the All Payer Claims Database (APCD). Access to the APCD will allow DPH to monitor health care costs within a community.

Clinical-Community Linkage Data

- DPH was funded to develop a fully electronic bi-directional referral system through a CMS State Innovation Model Testing Award e-Referral project (funded 4/1/2013). This linkage will allow DPH to link an individual using a community resource, such as a diabetes prevention program, directly to their electronic health records. This bi-directional referral system will not only allow providers to know if their patients are utilizing community resources, but also if those community resources are leading to improved health outcomes.

Community data

- By using geo-coded data from routine field and telephone surveillance, program specific data can be linked to the neighborhoods in which individuals live. Surveys of individuals could be random, address-based, or panel surveys. Contact methods have not yet been determined.


Hospital Data
(Case-mix)
All Payer Claims Database
(APCD)
KEY
Direct Link
Probabilistic Link
Community Link
Geo-codable
L/L
Geo-Coded Community-Level Data*
Mass in Motion (health behaviors and awareness)
Field Surveys
Grocery and convenience stores
Restaurants
Parks and Sidewalks
Telephone Surveys with self-reported
Awareness of initiatives
Behaviors (e.g., smoking, obesity)
Health
WIC / Snap sales
Registry of Motor Vehicle Mileage data
Crime statistics
Location of parks, trails, Farmer's Markets, etc.
Clinical Data
(MDPH net, CHIA DRVS)
L/L
E-Referrals (CTG or CMS Innovations)
L/L
Community*

Finally, Chapter 224 provides the mechanism to ensure that funded communities work through DPH to develop a rigorous program evaluation. The law states, "Each grantee shall participate in any evaluation or accountability process implemented or authorized by the department." Given the specificity of the outcome measures required, it is likely a data linkage mart similar to the one proposed here is necessary. The graphic above depicts one vision of the linkages and the methodology for creating these linkages across data sets.

PWTF Staffing and Funds Expended to Date

The PWTF staff at DPH will be organized into two teams: the Administrative Team and the Field Team. Both teams will be directed by the PWTF Program Manager. The Administrative Team's primary responsibilities include (with input from the Field Team): coordinating long term strategic planning, all written reports, quarterly learning session logistics and agendas; managing budgets and contracts; coordinating and planning evaluation processes; organizing and sharing data and other information (toolkits, learning session content) among staff and grantees; and convening all Prevention and Wellness Advisory Board meetings. In addition to the PWTF Program Manager, the Administrative Team includes three full-time staff: a Program Coordinator and two evaluators, along with two contractors providing logistic, writing and planning support. The Administrative Team also coordinates with other DPH staff and contractors including content experts, data and evaluation staff/contractors, a proposed health economist, administration and finance staff and legal staff.

The Field Team, also supervised by the PWTF Program Manager, is responsible for providing all quality improvement coaching and technical assistance to PWTF grantees, identifying best practices and suggesting content for learning sessions and speakers, monitoring and sharing progress on benchmarks and indicators and identifying toolkits and change packages to help grantees progress to outcome goals. The Field Team includes 1.5 FTE Nurse Clinical Quality Improvement Specialists, 1.0 FTE Partnership Technical Assistance/Quality Improvement Specialist, 1.0 FTE Intervention and Linkages Technical Assistance/Quality Improvement Specialist, and an IT contractor. The Field Team will coordinate with other DPH staff, some partially funded through the Trust, including community liaisons in the various regions of the state. This team will also rely on external Expert Faculty advisors (for identifying meaningful outcome and process measures and learning sessions) and internal DPH subject matter experts for content expertise.

Over the four-year life of the program, the Prevention and Wellness Trust will receive $57 million. The Prevention and Wellness Trust Fund budget for the four years allocates $8,550,000 (or 15%) for administrative and evaluation expenses including the staff described above, contractors to support evaluation, technical assistance, IT, and other support for funded partnerships. A total amount of $42,750,000 has been budgeted to fund grants and $5,700,000 for worksite wellness activities.

Through November 30, 2013, the Trust has received $18,914,812.41 with current expenses totaling $177,862.07. The funds expended to date include $126,386.14 for staffing related costs and $51,475.93 for consultant and logistical support for the listening sessions, bidders' conference and RFR. This constitutes 0.94% of funds received to date and 0.31% of total funds anticipated over the four-year life of the program.

The estimated budget for the first year of the Trust (July 1, 2013 – June 30, 2014) is currently estimated at $4,055,626 of which $2,250,000 will support community grants in the capacity building stages, $429,000 will be expended on worksite wellness technical assistance and activities and $1,376,626 will be spent on staff support, technical assistance and evaluation planning. DPH anticipates an annual budget of $17,611,928 for the remaining three years of the Trust.

Conclusions and Future Work

This is the first annual report describing the activities and outcomes of the Prevention and Wellness Trust Fund. We anticipate that the second report (CY 2014) will cover initial implementation work and improvements in process measures such as number of patients screened and services delivered. The third report (CY 2015) will focus on process measures as well as clinical and behavior changes such as improvements in blood pressure, reductions in injuries from falls, reductions in emergency department visits for asthma, and numbers of adults who quit smoking. The fourth report (CY 2016) will include process and clinical improvements as well as evaluations and estimations of health care cost reductions based on data obtained from the Massachusetts All Payer Claims Database.

In developing, implementing, and evaluating the Prevention and Wellness Trust Fund, DPH has set a course with the expectation that its efforts and the efforts of grantees will maximize the chances that the Commonwealth will succeed in reducing the prevalence of preventable health conditions and reducing the growth in health care costs. If successful, DPH and the PWTF grantees will have laid out a clear roadmap for future prevention and wellness initiatives in Massachusetts and elsewhere.

Appendix A

Brief descriptions of initiatives that the Trust is built upon:

All-Payer Claims Database: The APCD is comprised of medical, pharmacy, and dental claims, as well as information about member eligibility, benefit design, and providers for all payers covering Massachusetts residents. The APCD streamlines required data submissions for payers and also affords a deep understanding of the Massachusetts health care system by providing access to timely, comprehensive, and detailed data. The APCD is an essential tool to improve quality, reducing costs, and promote transparency.

CMS State Innovation Model Testing Award: Provides funding for the e-Referral project at DPH, which will build the infrastructure to electronically link individual patients to community-based resources through their provider's office.

Coordinated Chronic Disease Communities of Practice: Communities of Practice are groups of people with a shared concern on a specific topic that meet regularly to share expertise and solutions to recurring problems. DPH facilitates seven chronic disease-related communities of practice.

Community Transformation Grants: CDC-funded grant to implement a core set of aligned strategies to address key risk factors for obesity, and heart disease and stroke prevention in selected MA communities

Consolidated Chronic Disease Funding: Funding from CDC to support statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors. Four chronic disease prevention programs (Diabetes; Heart Disease and Stroke Prevention; Nutrition, Physical Activity, and Obesity; and School Health) are included. Collectively, these programs represent activities and intervention strategies that draw from each of the four chronic disease domains; epidemiology and surveillance; community environmental approaches, health systems interventions and community-clinical linkages.

The **Expanded Chronic Care Model** provides a framework for both public health and healthcare services to better address the needs of individuals with chronic disease(s), placing greater emphasis on prevention, population health promotion, and the creation of supportive community environments linked to the health care system.
Barr VJ, et al. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Hospital Quarterly. 2003. Vol 7(1);73-82. http://www.ncbi.nlm.nih.gov/pubmed/14674182

Massachusetts Asthma Prevention and Control Program: Funded by the Center for Disease Control and Prevention, the Program works to improve the quality of life for all Massachusetts residents with asthma and to reduce disparities in asthma outcomes.

Massachusetts Substance Abuse Programs: The Bureau of Substance Abuse Services funds 36 community-based prevention programs that utilize science-based programs/strategies to prevent alcohol, marijuana, and other drug abuse with a particular focus on the under 21 population. Each program focuses on a specific municipality or neighborhood and is carried out by a coalition comprised of organized community members that have interest in helping their community prevent substance abuse.

Massachusetts Tobacco Cessation and Prevention Program: The Massachusetts Tobacco Cessation & Prevention Program works to improve public health in the Commonwealth by reducing death and disability from tobacco use.

Mass in Motion: Mass in Motion is a Massachusetts statewide movement that promotes opportunities for healthy eating and active living in the places people live, learn, work and play.

MDPHnet: MDPHnet is a joint project of Massachusetts Department of Public Health (MDPH), the League, DPM, Lincoln Peak Partners (LPP), and the Massachusetts eHealth Institute (MeHI) to establish a platform through which MDPH and Massachusetts League of Community Health Centers (MLCHC) staff and community health center providers can access population health reports for influenza-like illness and diabetes that are timely and useful. Evaluations will be performed to assess the usability of the MDPHnet portal as well as the data generated from ESP and MDPHnet.

Model Wellness Guide: Chapter 224 also called for DPH to develop a Model Wellness Guide for consumers, employers, and payers. It is divided into three sections: the first contains information on the importance of healthy lifestyles in the prevention and control of chronic diseases, the second includes evidence-informed guidance on developing worksite wellness programs for employers, and the final section lists a variety of resources on worksite wellness, both general and intervention-specific.

The National Prevention Strategy and the National Quality Strategy both include population health goals to improve prevention and treatment of chronic diseases. These goals create a bridge between improvements that support public health and individual health status and are attainable only through the coordinated efforts of both the clinical and community systems. http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf, www.ahrq.gov

Wellness Tax Credit: The Massachusetts Wellness Tax Credit Incentive gives small businesses in Massachusetts a state tax credit for having an employee wellness program.

Appendix B

Prevention and Wellness Advisory Board Members Brief Bios

1. A person with expertise in the field of public health economics:

David Hemenway, Ph.D. - Professor of Health Policy, Department of Health Policy and Management, Harvard School of Public Health

Dr. Hemenway is Professor of Health Policy at the Harvard School of Public Health. He has a B.A. (1966) and Ph.D. (1974) from Harvard University in economics. He is the director of the Harvard Injury Control Research Center and the Harvard Youth Violence Prevention Center. He is also currently a James Marsh Visiting Professor-at-Large at the University of Vermont. Dr. Hemenway has written over 130 articles and five books in the fields of economics and public health.

2. A person with expertise in the field of public health research:

Stephenie C. Lemon, Ph.D. – Associate Professor of Medicine, Division of Preventive and Behavioral Medicine and Associate Professor, Graduate School Biomedical Sciences, Ph.D. Program in Clinical and Population Health Research, University of Massachusetts Medical School

Dr. Lemon holds dual appointments in the Department of Medicine and the Graduate School of Biomedical Sciences Ph.D. Program in Clinical and Population Health Research both at the University of Massachusetts Medical School, since 2008. She has been an Assistant Professor of Medicine since 2002 and an Assistant Professor of Graduate School Biomedical Sciences Ph.D. Program in Clinical and Population Health Research since 2004. She received her Ph.D. from Brown University. Dr. Lemon serves as principle investigator or co- investigator on numerous CDC or NIH grants and has authored or co-authored over 49 peer-reviewed journal articles on public health topics related to the prevention and control of chronic diseases. She currently serves on the MA Comprehensive Cancer Prevention and Control Advisory Board to the DPH and contributes significantly to surveillance and evaluation work related to Mass in Motion.

3. A person with expertise in the field of health equity:

To Be Appointed

4. A person from a local board of health for a city or town with a population greater than 50,000:

Paula Johnson, MD, MPH – Chair, Boston Public Health Commission

Dr. Paula A. Johnson is the Executive Director of the Connors Center for Women's Health and Gender Biology and Chief of the Division of Women's Health at Brigham and Women's Hospital, as well as Professor of Medicine at Harvard Medical School. An internationally recognized cardiologist, Dr. Johnson brings a broad range of experience as a physician, researcher and expert in public health and health policy to bear in the effort to transform the health of women. Her most recent work focuses on the impact of U.S. health care reform on women.

Dr. Johnson serves as Commissioner and chair of the Board of the Boston Public Health Commission. She has served as a member of the National Institutes of Health (NIH) Advisory Committee on Research on Women's Health, and currently serves on numerous national and international committees, most recently the Institute of Medicine (IOM) Committee on Preventive Services for Women. She attended Harvard and Radcliffe Colleges, received her MD and MPH degrees from Harvard and trained in internal medicine and cardiovascular medicine at Brigham and Women's Hospital.

5. A person from a local board of health for a city or town with a population of fewer than 50,000:

Heidi Porter MPH, REHS/RS - Director of Public Health, Town of Bedford, MA

Since March 2011, Ms. Porter has served as the Director of Public Health for the town of Bedford. She has also served as Director of the Board of Health in Everett. Ms. Porter holds an MPH with a concentration in Environmental Health from Boston University School of Public Health and a Bachelor of Science from Tufts University. She is also a Registered Environmental Health Specialist/Registered Sanitarian. Ms. Porter has received numerous awards for her innovations and leadership. She serves on several committees and is a member of the Massachusetts Environmental Health Association, MA Licensed Site Professionals Association and the Massachusetts Health Officers Association. DPH staff has worked with Ms. Porter on policy, systems and environmental approaches to health promotion over the past several years.

6 and 7. Representatives of health insurance carriers: (2 appointees)

MaryLynn Ostrowski, Ph.D. - Director, Corporate Relations, Brand and Population Health Management, Health New England

Dr. Ostrowski has been with Health New England since 1993 and has served as the director since July of 2012. She is responsible for the development, implementation, and measurement strategy for member and employer health engagement programs, which includes health coaching, behavior modification, health screenings, health risk assessments, and disease management. Dr. Ostrowski received her Ph.D. in Health Psychology from Capella University, Minneapolis, MN and is a Master Trainer for the Stanford University Chronic Disease Self Management Program. In addition, she serves on the Mass in Motion/Springfield Wellness Leadership Council, the Women's Fund LIPPI Board, Foundations of Health Board at Holyoke Community College, Live Well Springfield Kids Board and the Partners for a Healthier Community Board

Cathy Hartman – Vice President, Prevention and Wellness, Blue Cross Blue Shield of Massachusetts

Ms. Hartman is an accomplished and energetic health and care management professional with extensive experience in designing and launching wellness and disease prevention initiatives with multi-disciplinary teams. She possesses deep subject matter expertise in the science of behavior change using motivational interviewing and other evidence-based approaches and has a successful track record in conceptualizing, developing, and executing innovative and integrated solutions to meet changing internal and external business needs.

8. A person from a consumer health organization:

Susan Servais - Executive Director, Massachusetts Health Council, Inc.

Ms. Servais has served as the Executive Director of the Massachusetts Health Council since 1988. The Massachusetts Health Council is a 152-member non-profit organization focused on improving the health of individuals and communities through prevention, access to care, eliminating disparities and improving quality. Ms. Servais holds a BS degree from Simmons College. She comes highly regarded from members of the Council and has their many resources available to support the work of the Wellness & Prevention Trust Fund.

9. A person from a hospital association:

Peter Holden - Board Member of the Mass Hospital Association and President and Chief Executive Officer of Jordan Health Systems, Inc.

Mr. Holden has over 30 years of experience in Hospital Administration and joined Jordan Hospital in October, 2007. He serves as President and Chief Executive Officer of Jordan Health Systems, Inc. and several of its subsidiaries. Mr. Holden holds a Masters in Hospital Administration from Xavier University, Cincinnati, Ohio. Under his leadership Jordan Hospital has developed a close working relationship with community partners and currently works closely with the Town of Plymouth to implement the Mass in Motion campaign. He also is a co-leader in convening the Plymouth Youth Development Council that is seeking to implement evidence-based interventions to address drug use and other risk-taking behaviors throughout the school district.

10. A person from a statewide public health organization:

Tobias Fisher was appointed to the Board. At the time, Mr. Fisher was the Executive Director of the Massachusetts Public Health Association (MPHA). He has left his position at MPHA and this position representing a statewide public health association on the Board is now vacant.

11. A representative of the interest of businesses:

Keith Denham - Partner in the Audit and Enterprise Risk Services (AERS) practice with Deloitte & Touche LLP

Mr. Denham is a Partner in the Audit and Enterprise Risk Services (AERS) practice with Deloitte & Touche LLP, where he leads the Northeast Advisory Services group, which has more than 1500 professionals. His leadership contributed to Deloitte's Advisory practice being acknowledged by Forrester Research as "the leader in information security consulting as well as IT Risk Consulting" and by Kennedy Information as the "leader in global risk management consulting". Keith combines a dedication to his profession with a commitment to mentorship, development and being deeply involved in the Massachusetts community, where he has a relentless focus on volunteerism and civic progress. This focus has resulted in recognition for his contributions from some of the most important regional not for profits and community organizations.

12. A person who administers an employee assistance program:

Robert Bruce Cedar, Ed.D. - President/Owner, CMG Associates

As the owner of CMG Associates since 1997 Dr. Cedar has been responsible for the development and management of employee assistance programs and services, clinical and consultation services, executive coaching, organizational consulting, trauma intervention and crisis work, threats of violence consultations, leadership training, wellness seminars and SAP (DOT) evaluations. CMG Associates has been providing Employee Assistance Program (EAP), Management Consultation, Crisis Management and Training services in the Northeast and throughout the country. We currently provide a comprehensive EA program to the Commonwealth of Massachusetts Secretariat of Health and Human Services as well as a number of other state agencies. Dr. Cedar received both an Ed.D. and Ed.M. degrees in Counseling Psychology from Boston University.

13. A public health nurse or a school nurse:

Karen Regan, RN, BSN - Supervisor of School Nurses, New Bedford Public Schools

Ms. Regan has been supervisor of school nurses New Bedford Public Schools since 1994. The school system has approximately 13,000 students. She is co-chair of the School Health Advisory committee. She received a Master of Science in Nursing (MSN) from UMASS Dartmouth and a Bachelor of Science in Nursing (BSN) from Salve Regina University. She is a member of the National Association of School Nurses. She has demonstrated great leadership in supporting DPH's implementation of a national demonstration grant Mass in Motion Kids, a childhood obesity pilot study.

14. A person from an association representing community health workers:

Lisa Renee Holderby-Fox - Executive Director, Massachusetts Association of Community Health Workers (MACHW)

Ms. Holderby-Fox has nearly 20 years experience as a community health worker. She has been Executive Director of the Massachusetts Association of Community Health Workers since 2011 and was a founding member and board chair. She is a member of the National Healthcare Workforce Commission.